COUNTY OF SAN LUIS OBISPO BOARD OF SUPERVISORS
AGENDA ITEM TRANSMITTAL

(1) DEPARTMENT	(2) MEETING DATE	(3) CONTACT/PHONE
Public Health	11/15/2011	Penny Borenstein 781-5519

(4) SUBJECT

Report on the County Indigent Medical Care System, Federal Health Care Reform and California's "Bridge to Reform" Section 1115 Waiver: the Low Income Health Program

(5) RECOMMENDED ACTION

It is recommended that the Board:

1. Receive and file this report regarding the County Indigent Medical Care System, Federal Health Care Reform and California's "Bridge to Reform" Section 1115 Waiver: The Low Income Health Program

2. Provide staff direction regarding any additional action required

(6) FUNDING SOURCE(S)	(7) CURRENT YEAR FINANCIAL IMPACT	(8) ANNUAL FINANCIAL IMPACT	(9) BUDGETED?
N/A	$0.00	$0.00	N/A

(10) AGENDA PLACEMENT

{ } Consent **{ }** Presentation (Time Est._____) **{ }** Hearing (Time Est. _____) **{ x }** Board Business

(11) EXECUTED DOCUMENTS

{ } Resolutions **{ }** Contracts
{ } Ordinances **{ x }** N/A

(12) BUDGET ADJUSTMENT REQUIRED?

BAR ID Number: N/A
{ } 4/5th's Vote Required **{ x }** N/A

(13) OUTLINE AGREEMENT REQUISITION NUMBER (OAR)

N/A

(14) W-9

{ x } No **{ }** Yes

(15) LOCATION MAP	(16) BUSINESS IMPACT STATEMENT?	(17) AGENDA ITEM HISTORY
N/A	No	**{ }** N/A Date 10/5/2010

(18) ADMINISTRATIVE OFFICE REVIEW

(19) SUPERVISOR DISTRICT(S)

All Districts -

County of San Luis Obispo

TO: Board of Supervisors

FROM: Public Health / Penny Borenstein
781-5519

DATE: 11/15/2011

SUBJECT: Report on the County Indigent Medical Care System, Federal Health Care Reform and California's "Bridge to Reform" Section 1115 Waiver: the Low Income Health Program

RECOMMENDATION

It is recommended that the Board:

1. Receive and file this report regarding the County Indigent Medical Care System, Federal Health Care Reform and California's "Bridge to Reform" Section 1115 Waiver: The Low Income Health Program

2. Provide staff direction regarding any additional action required

DISCUSSION

The purpose of this report is to provide an overview of anticipated changes in the County's health care delivery system related to federal health care reform, and the effect that those changes may have on the County's fiscal and program obligations over the next few years.

Patient Protection and Affordable Care Act (PPACA)
The Patient Protection and Affordable Care Act (PPACA) of March 23, 2010 (or *federal health care reform)* has had and will continue to have broad implications for the nation's current system of health care delivery. Particularly relevant components of the PPACA for the County, slated to become effective in January 2014, relate to expansion of health insurance coverage for low-income populations.

On January 1, 2014, federal Medicaid, known as Medi-Cal in California, will expand eligibility to include all legal residents between the ages of 19-64 years old whose household incomes are at or below 133% of the federal poverty guidelines/level (FPL). In addition, at the start of January 2014, all uninsured legal residents with household incomes in the range of 134%-400% FPL will have access to purchase federally-subsidized insurance through a state-run Health Benefits Exchange (henceforth "the Exchange".) The subsidy will come in the form of tax credits and will apply to both premiums and cost-sharing.

California's 1115 Demonstration Waiver and the Low-Income Health Program
The Medicaid program, established under the federal Social Security Act (SSA) of 1965, is defined by laws, regulations and rules under which states may operate a Medicaid program, in partnership with the federal government, to provide health care benefits to low-income and other special populations. Under section 1115 of the SSA, states may apply to the federal Centers for Medicare and Medicaid Services (CMS) to waive selected provisions of the SSA for experimental, pilot, or demonstration projects and to use Medicaid funds for expenditures that otherwise would not be permitted under federal law. Last year, the California Department of Health Care Services (CDHCS) applied to the CMS for a so-called 1115 Demonstration Waiver entitled "Bridge to Reform". Approved November 1, 2010, this five-

year $10 billion waiver will allow CDHCS to implement changes to the Medi-Cal program that will help the state transition to the federal reforms scheduled to take effect January 2014. One central component of the state's newest waiver is a provision to allow local rather than state funds to be used to draw down federal matching dollars, and to dedicate those funds to expand coverage early for those who will become newly eligible for coverage in 2014 under the PPACA.

The state estimates that the waiver will increase and expand health care coverage to as many as 500,000 low-income uninsured residents through this new program they now call the Low Income Health Program, or LIHP. The state's LIHP is a county-based coverage initiative that allows counties the option to participate and provide this program to their residents. Eligible adults enrolled in a LIHP will receive a core set of services, much like Medi-Cal, including inpatient and outpatient hospital services, prescription drugs, mental health services, and other preventative and medically necessary services. As the LIHP terminates on December 31, 2013, so too will this portion of the waiver and LIHP enrollees will transition directly into the expanded Medi-Cal program or will be able to access insurance through the Exchange.

Counties participating in a LIHP program can use county funding sources, known as Certified Public Expenditures (CPE), and expect to be reimbursed a 50% share of federal dollars. The County however must expend all the cost, known as Total Net Expenditure (TNE), in order to receive the federal match; i.e., for every $2 spent by a county, $1 will be reimbursed from the federal government. Further, counties must demonstrate to the state that CPE used for their LIHP and for any continued Medically-Indigent Services Programs (MISP) will be maintained or increased above FY 2009/2010 MISP expenditures. This baseline expenditure requirement, called the Maintenance of Effort, or MOE, must be demonstrated each year of the LIHP program.

While the LIHP includes a core set of benefits, counties are given some flexibility in program design and eligibility criteria. LIHP consists of two sub-programs with different levels of eligibility criteria and benefits. A LIHP must include the Medi-Cal Expansion (MCE) program, which includes some or all persons who will become Medi-Cal eligible in 2014; i.e., non-elderly adults with incomes at or below 133% FPL, provides a core set of benefits, and has no cap on federal matching fund reimbursements. In addition to the MCE, a LIHP may choose to also include the Health Care Coverage Initiative (HCCI) sub-program, which includes adults with slightly higher income levels between 133 and 200% of FPL, provides fewer benefits than those offered in the MCE, and has a cap on federal matching fund reimbursements.

The County Medical Services Program (CMSP) and LIHP

CMSP was implemented by the County in 1982 when California decided to eliminate full-scope Medi-Cal coverage for low-income adults and shift the responsibility for the provision of medical care for these medically indigent adults to county-based Medically Indigent Services Programs (MISPs). San Luis Obispo County named its MISP the County Medical Services Program (CMSP). Though not a specified program prior to 1982, counties have long had an obligation to provide for medical needs of their medically indigent adults under state Welfare and Institution Code, Section 17000.

The state initially provided grant funding for these newly created programs; when California passed *Realignment* of a broad range of health and human service programs, including the MISP in 1991, grant funding was replaced by a dedicated set of tax initiatives to allow counties to sustain their MISPs. Soon after the 1991 realignment, the tax revenue failed to keep pace with the cost of the CMSP; and the expense has been on an increasing trajectory ever since. As such, the County has been supplementing realignment funding with General Fund support (GFS). A rise in GFS occurs especially during times of economic downturn, as has been experienced in the last several years, as more people fall into a CMSP-eligible status coincident with a decline in realignment tax revenue.

Unlike MISPs, LIHPs are optional for counties. LIHP and our local CMSP are similar in that they serve this county's medically indigent adults between 19-64 years of age, who may not be otherwise eligible for Medi-Cal, are not pregnant, and must be legal, permanent US residents. CMSP eligible applicants must have household incomes below 250% FPL, are subject to limitations of personal assets, and enrollment can not be capped. CMSP is not an insurance program and covers only the cost of medical care based on an applicant's qualifying medical condition with periods of coverage as short as 30 days. In contrast, LIHP is designed to provide comprehensive medical benefits similar to Medi-Cal, with eligibility redeterminations just once a year.

Some counties plan to transition their existing MISPs into their new LIHPs, thereby opting for a single county-based program to provide for the medical needs of their indigent adult residents. Staff evaluated this option and determined that, while some administrative cost savings would be gained by combining CMSP into LIHP, the net cost effect is prohibitive due to the expanded scope of benefits in LIHP.

The LIHP Planning Project
The County's LIHP planning project began in September 2010 when the Health Agency formed a workgroup comprised of all stakeholders concerned with the provision of health care to this population. Under a planning grant received from the Blue Shield California Foundation and approved by your Board on October 5, 2010, this workgroup, with direction from staff and a consultant, has spent the past year evaluating the potential benefits of the County's participation in the LIHP, what the LIHP would look like, and what collateral effects participating would have on the CMSP and the County's financial obligations, both now and after implementation of PPACA in January 2014.

Initially, staff and the workgroup believed it made sense to participate in LIHP to the full extent; i.e., include all persons eligible up to 200% FPL. It seemed that would be possible by matching all of the local funds currently supporting CMSP. In broad terms, the thought was that if CMSP expends roughly $7M currently, then under a LIHP the County could expect another $7M of federal funds. Upon further analysis it became clear that the cost of comprehensive health care services for an expanded population would far exceed even a doubling of revenue to support such a program. Estimates of the cost of covering an anticipated enrollment of roughly 7000 eligible persons are closer to 4-6 times the current expenditure, or $30-45M, an amount that obviously the County cannot afford.

Accordingly, staff has regrouped and tried to re-evaluate if LIHP participation is feasible at considerably lower enrollment numbers, managed by more restrictive eligibility criteria and an enrollment cap. In so limiting LIHP, the County would retain a substantial obligation for the remainder of the CMSP-eligible population, and thus a portion of the current CMSP expenditure would need to continue to be covered by realignment and GFS. Current analysis shows that the County may only be able to afford LIHP coverage for the lowest financial strata, perhaps only those who are unemployed and receiving no income or who receive only General Assistance from the Department of Social Services. Titrating the amount of revenue that can be allocated to LIHP and determining the number of people that level of funding would cover is challenging. While limiting the number of enrollees is planned, health care utilization and thus total program cost can only be estimated. Add to that dilemma the need to have a solid estimate of the cost of the residual CMSP program and the decisions become even more complex. While CMSP and LIHP are separate programs, the two are linked financially due to their mutual responsibility to serve our County's medically indigent population.

Staff is proceeding with our analysis and development of several components of the program as new requirements for LIHP are disclosed and applicable data is updated. We have worked closely with CenCal, our county's Medi-Cal managed care plan, throughout this process to attain and refine the best available utilization estimates and associated costs. Further, we have conceptual agreement from key LIHP providers on our proposed funding methodology which includes a shared risk element. Other operational tasks remain such as submission and acceptance of all deliverables by CDHCS, fee negotiation and contract development with providers and third party administrator for LIHP and CMSP, as well as design and implementation of an integrated eligibility and enrollment system for LIHP and CMSP.

Community Health Centers and its Relationship to the CMSP and LIHP
In 2004, the County began a unique relationship with the Community Centers of the Central Coast (CHC), especially as related to the provision of CMSP services. Heretofore, the County itself was both payer and provider of health care to CMSP clients. With the closing of the county General Hospital in 2003 and the resultant rise in the rate of unreimbursed outpatient medical care, the County sought a more cost-efficient manner to assure the provision of care to low-income uninsured persons. The result was a contract with the CHC for primary, ancillary, and limited specialty care as well as for pharmacy services. For the first four years of that contractual relationship, an increasing amount of grant funding was provided to cover not only CMSP clients but also other low-income, unsponsored (uninsured) residents. Beginning in fiscal year (FY) 2008-09, owing to the Great Recession and the County's worsening financial picture, the amount of funding to CHC has decreased annually, from a high of roughly $5.2 million in FY 2007-08 to the current FY 2011-12 of $2.5 million.

While the nature of the contract between the CHC and the County continues as a lump sum grant rather than a fee for service arrangement, the amount of current funding is believed to be relatively close to what it might cost the County to purchase the contracted services for CMSP clients on a fee for service basis. Thus having the availability of additional federal funding through a LIHP to support the health care services that CHC provides to the CMSP and LIHP-eligible populations would presumably be a win-win. In order to achieve this outcome, the County will need to partner with CHC to allow fluidity between the financing arrangements for the two programs while still meeting the separate requirements of LIHP and CMSP and providing a fair rate of return to CHC for the additional health care services envisioned under LIHP.

2014 and Beyond
Upon full implementation of the coverage expansion elements of the PPACA, the obligation to retain the CMSP as it is currently configured would be negated. For the first five years of the Medicaid expansion, the federal government will bear 100% of the costs for the new Medi-Cal enrollees, those aged 19-64 with household incomes below 133% FPL. The remainder of current CMSP enrollees, those with incomes 134-250% FPL, will be eligible to purchase insurance through the Exchange.

Unknowns include what might be the County's obligation under W&I Code 17000 to provide for the medical care of those who do not enroll, and how will the state address the existence of the health care sub-account crafted under the 1991 Realignment.

Additional considerations that need thoughtful planning at this juncture include ensuring expanded health care capacity will be available when newly insured populations begin to seek greater access to a full continuum of health care services, and how to do that in a fiscal environment that is expected to further contract over the next two or more years.

Outstanding Considerations for the County's Decision on LIHP Participation
The overall cost benefit analysis of our participation in LIHP remains challenging. In the end LIHP is not expected to provide health care coverage for more people, but would instead provide more consistent and comprehensive health care benefits than those offered in the CMSP. While LIHP has the potential to significantly improve the health care of a limited number of people, it will require significant program development and commitment from the County for just a short time.

Further, care needs to be taken to avoid any untoward effects on the remainder of the Health Agency's realigned programs. Should participation in LIHP result in increased MOE going forward such that the state resets the amount they would consider "no longer necessary" under realignment, the loss of those county funds could result in a decrement to other public health and mental health programs.

Staff has no recommendation to the Board at this time regarding the County's implementation of LIHP; however, we are proceeding with our analysis and development of several components of the program and hope to provide the Board with a recommendation in the coming weeks.

If the County does decide to implement the LIHP, our original projected start date of January 1, 2012 is no longer valid, and a March or April start date is more likely. We are currently in what the CDHCS calls the authorization phase of LIHP implementation, to be followed by the contracting phase.

OTHER AGENCY INVOLVEMENT/IMPACT

Health Agency staff has collaborated with many entities in assessing the best path forward with regard to LIHP participation and the ensuing expansion of health care coverage in 2014. Health care providers including hospital executives, emergency medicine physicians, CHC, and others through the SLO County Medical Association have been engaged in the process of information gathering and evaluation. DSS has been involved in the workgroup and in planning for integrating enrollment systems between CMSP and Medi-Cal. CenCal has played a significant role in securing an adequate provider network and preparing for a role as third party administrator for LIHP. County Counsel is currently undertaking the review of the boilerplate contract provided by CDHCS.

FINANCIAL CONSIDERATIONS

No financial considerations are required with this item.

RESULTS

Staff anticipates providing a recommendation to the Board within the next month regarding implementing a LIHP. Should the County conclude that it will indeed proceed, the improved access to comprehensive health care services for LIHP-enrolled residents will contribute to the county-wide goal of a healthy community.

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